## Referral to Community Based Rehabilitation Service

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| **Please ensure all sections of this referral are completed for it to be processed in a timely manner. Email completed form as a pdf to** [**tth-referrals@health.qld.gov.au**](tth-referrals@health.qld.gov.au)  Townsville Hospital and Health Service (THHS) provides intensive, time-based rehabilitation in the community. Programs are delivered by an experienced interdisciplinary team including physiotherapy, occupational therapy, exercise physiology, speech pathology, dietetics, diabetes education, psychology, neuropsychology, and social work. Centre based programs are offered across the Townsville Region including outreach to Ayr, Charters Towers, Ingham, Magnetic Island, Palm Island, Richmond, and Hughenden. Referrals will be managed by THHS and triaged through a central referral hub. |

**Participant Details**

URN: Sex:  Male  Female

Family name: Phone (Home):

Given name: Phone (Work):

Address: Email Address:

Date of Birth: Country of Birth:

Discharge Information (if different to above)

Address: Phone (Best):

Aboriginal/Torres Strait Islander Status:

N/A  Aboriginal  Torres Strait Islander  Both Aboriginal and Torres Strait Islander

**Key Contacts:**

**General Practitioner:**

Full Name: Phone (Work):

Practice Name: Fax (Work):

**Emergency Contact / NOK:**

Full Name: Phone (Best):

**Medical Clearance:** This section must be completed by a medical practitioner.

Please identify any recommendations, precautions, limitations or restrictions for this participant:

1. Are they medically safe to participate in physical activity:  Yes  No

2. Are they safe to participate in water-based activities:  Yes  No

3. Is there any precautions / restrictions / limitations that needs to be   
 observed during the program (includes PMH and current MHx)?  Yes  No

Please explain:

*E.g.: Epilepsy (if yes, please attach the seizure management plan), Cardiac history, Spinal pathologies.*

Doctor’s Name: Signature

Provider #: Date

**Is this a Driving Referral?:**

Yes > You must complete the separate ‘Referral for Driving Assessment’ in addition to this referral (Attached? )

No > Continue to next Section

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| Rehabilitation goals of referral: |

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| Presenting health condition/Diagnosis: |

**Has there been a recent hospital admission?**

Yes  No (If Yes, provide Date/Reason/Length of stay & Medical Clearance from your G.P).)

**Have referrals been sent to services other than Alliance Rehabilitation?** (Please list)

**Are there other services currently involved?**

Home care package  Private Allied Health   
 Community support i.e Kith & Kin  Other (specify):

**Is this person involved with Office of Public Guardian (OPG)?**

Yes  No

**Does this person require support for communication (eg. aphasia / interpreter)**

Yes  No

**Please mark any that apply:**

Medicare  My Aged Care  DVA Gold  DVA White  NDIS  Insurance/Compensation Membership/Identification #

**Consent for referral**

Yes - this referral has been discussed with the participant and/or their guardian, and they understand and agree with the referral being made.

**Referrer Details:**

Referrer Name: Phone (Work):

Discipline: Fax (Work):

Address: Email:

Signature: Date

Common Indications for Referral:

* Rehabilitation post deconditioning including after surgical or medical admission e.g. recurrent falls where multidisciplinary intervention is required. Interventions are targeted at community management and prevention of hospital admission
* Specialist nursing including bowel, bladder, wound and pressure area management
* Driving assessment, vehicle modification and driving cessation
* Psychosocial Adjustment and community re-integration support
* Hydrotherapy
* Specialist management of hypertonicity
* Management for complex obesity and related mobility and community access concerns. Focus on social inclusion and long-term outcomes to avoid hospital admission
* Cardiac Rehab and Smoking Cessation (palm island)
* Parkinson’s intervention including LSVT Big and LSVT Loud
* Skills to Enable People and Communities (STEPS) – Acquired Brain Injury Program